O·A·R

Established 1971

BREAKING THE CYCLE OF CRIME WITH OPPORTUNITIES, ALTERNATIVES, AND RESOURCES

Consent to Exchange & Release Information

I understand that different agencies provide different services and benefits. Each agency must have specific information in order to provide services and benefits. By signing this form, I am allowing designated agencies to exchange certain information in order to provide or coordinate these services or benefits.

My name is _____ (please print)

My relationship to the client is: ___ Self ___Parent ___Power of Attorney ___Guardian ___Other

I want the following confidential information about the client (except drug or alcohol abuse diagnosis or treatment) to be exchanged:

Assessment Information	Medical Diagnoses/Prognosis	Education Record
Progress Reports	Criminal Justice Records	Financial Information
Employment Information	Housing Information	Mental Health Records
Benefits/Services	Emergency Contact Information	

Other Information (specify) _____

I want this information to be exchanged ONLY for the following purposes:

Service Coordination Eligibility Determination for Services Other _____

I want the staff members of OAR of Fairfax County, Inc, who are involved in my case, and the following agencies to be able to exchange this information in writing, by phone, or computerized data/fax:

Alcohol Safety Action Program
Client's Attorney _____
Community Service Worksites _____
Coordinated Services Planning
Court _____
Dept. of Family Services _____
Emergency Contact Information_____
Employer/Employment Referrals _____
George Mason University
Halfway House _____
Homeless Shelter _____
Immediate Family member_____
Legal Services of Northern Virginia
Local Human Services Agencies _____
Motel _____
Northern VA Comm. College
Police Department _____
Referral Source _____
Sheriff's Department _____
Skill Source Center _____
VA Department of Criminal Justice Services
VA Dept. of Corrections
VA Dept. of Vital Statistics
Victim Services _____
Workforce Investment Board

Other _____

This consent is good for one year after the date below or for the duration of my participation in an OAR program. I can withdraw this consent at any time by telling the referring agency. This will stop the listed agencies from sharing information after they know my consent has been withdrawn. I have the right to know what information about me has been shared, when, and with whom it was shared. If I ask, each agency will show me this (written) information. I want all the agencies to accept a copy of this form as a valid consent to share information. If I do not sign this form, information will not be shared and I will have to contact each agency individually.

Signature: _____Date_____

Witness (OAR Staff):_____Date:_____

Witness: _____Relationship to Client: _____Date:_____

(Two witnesses are recommended if this form must be read aloud to the client signing.)

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